Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
FEIN, STEPHEN J.	10/17/46	☒ Male	[redacted]

5. Employee's Home Mailing Address (no., street, city, state, zip code)	6. Home Telephone
522 SHORE ROAD LONG BEACH, N.Y. 11561	Area Code: 516 Number: 889-4329

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
NAVAL STATION NEW YORK 207 FLUSHING AVENUE BROOKLYN, N.Y. 11251-5000	304 Mitchel Ave EAST Meadow, N.Y (NAVY HOUSING Quarters)

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
6/21/88 10:00 ☒ AM ☐ PM	6/23/88	Wife/Husband ☒ Children/Under 18 Years Old ☐	HOUSING MANAGER

13. Cause of Injury (Describe how and why the injury occurred)

Inhalation of Chemical fumes in freshly sanded Naval quarters apartments, that had not been ventilated.

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)

Chest, lungs, throat, eyes, fingers and legs, and dizzyness occured at that time.

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

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16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or Annual leave.

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Mr. Stephen J. Fein was unable to sign. He was rushed to a physician.

Signature of Employee or Person Acting on His/Her Behalf

PENALTY PROVISION: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate U.S. Criminal Code provisions, be punished by a fine of not more than $10,000 or imprisonment for not more than five years, or both.

17. Statement of Witness (Describe what you saw, heard or know about this injury)

See attached Statement of Witness

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Oct. 1983

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: NAVAL STATION NEW YORK

22. Bureau or Office — Agency Code: 6403 LC

23. Name and Address of Reporting Office (No., street, city, state, Zip Code): PUBLIC WORKS DEPT., BLDG. #2, 207 FLUSHING AVENUE, BROOKLYN, NEW YORK 11251

24. Regular Work Day — Begins ☐ AM ☐ PM — Ends ☐ AM ☐ PM

25. Number of Hours Worked Per Day:

26. Circle Days Paid Per Week: S M T W T F S

27. Date and Hour of Injury (mo., day, year) ☐ AM ☐ PM

28. Date Reporting Office Received Notice of Injury (mo., day, year)

29. Date and Hour Stopped Work (mo., day, year) — Pay Rate $ _____ per____

30. If Pay Has Been Terminated, Give Date (mo., day, year)

31. 45 Day Period Begins (mo., day, year)

32. Employee's Grade and Step on Date of Injury — Grade_____ Step____

33. Date and Hour Employee Returned to Work (mo., day, year) ☐ AM ☐ PM

34. Name of Supervisor at Time of Injury

35. Was Employee in Performance of Duty At The Time of Injury? ☐ Yes ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self of Another?
☐ Yes ☐ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☐ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury (mo., day, year): 6/21/88

39. Name and Address of Physician First Providing Medical Care: Doctors Office Center Front Street East Meadow New York

40. Do Medical Reports Show Employee is Disabled For Work? ☐ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions:
☐ No Lost Time and No Medical Expense. Place This Form In Employee's Official Personnel Folder.
☐ Medical Expense Incurred or Expected. Forward This Form To OWCP.
☐ Lost Time Covered By Leave, LWOP, or COP. Forward This Form To OWCP

44. All Information Requested On This Form Has Been Furnished. If Not, It Will Be Submitted By _____ (Fill in Date)

45. Signature of Supervisor: Thomas P Reilly

46. Title and Office Phone Number: HOUSING DIRECTOR 718 834 2261

47. Date (mo., day, year): 6 22 88

PENALTY PROVISIONS: An immediate superior who hinders the filing of any compensation claim or report may be punished by a fine of not more than $500 or imprisoned not more than one year, or both – 18 U.S.C. 1922. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact in respect to this claim may also be subject to appropriate